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Abstract

Treatment-resistant psychosis is a challenge to psychiatry and a substantial burden to health-care systems. The province of British Columbia in Canada has publicly funded, universal health care, and patients with treatment-resistant psychosis may receive care in a specialized residential program. In 1993, a unit for specialized management of treatment-resistant psychosis was established at Riverview Hospital in Coquitlam, British Columbia. Patients admitted to this program; this cohort contains one of the largest known series of patients with treatment-resistant schizoaffective disorder.

All patients were evaluated by a psychiatrist, social worker, pharmacist, nurse, general physician, and neuropsychologist. Records from previous hospital admissions were reviewed and all information was presented at a multi-disciplinary conference. This resulted in a consensus DSM-III or -IV multiaxial diagnosis and a detailed treatment plan. Ratings of symptoms and functioning at admission and discharge included the Positive and Negative Syndrome Scale (PANSS), the Global Assessment of Functioning Scale, and the Clinical Global Impression of Severity. A research psychologist compiled all data at the time of each patient’s hospitalization.

Patients who did not complete treatment or had a diagnosis other than schizophrenia (SZ), schizoaffective (SZA) or mood disorder (MD) were excluded; the following describes 551 included patients (SZ = 63%, SZA = 29%, MD = 8%). More than half were male (62%), and the mean duration of hospitalization was 30 weeks. The proportion receiving clozapine increased from 21% at admission to 61% at discharge. Those with a MD were less likely to receive clozapine than either SZ or SZA (SZ = 64%, SZA = 61%, MD = 41%). In each diagnostic group, both antipsychotic polypharmacy and the ratio of prescribed daily dose to defined daily dose (DDD) of antipsychotic medication decreased during hospital stay (polypharmacy: SZ: 52% to 16%, SZA: 52% to 2%, MD: 43% to 0%; DDD: SZ: 2.1 to 1.6, SZA: 2.1 to 1.4, MD: 1.6 to 1.1). The use of mood stabilizers declined in all groups, but anti-depressant use declined only in SZ and SZA. Mean total PANSS score declined in all diagnostic groups, but most in MD, least in SZ, and intermediate in SZA.

In an intensive inpatient program for treatment-resistant psychosis, aggregate improvement occurred despite global reduction in medications while clozapine use nearly tripled. Lower total antipsychotic dose correlated with greater improvement at discharge.

Conclusions

Among patients referred for intensive management of treatment-resistant psychosis in British Columbia from 1993-2011:

• Most patients were not receiving clozapine in the community.
• At the time of discharge, the proportion of patients on clozapine increased greatly and antipsychotic polypharmacy declined.
• Treatment response as measured by decrease in mean total PANSS score occurred in all diagnostic groups, but patients with mood and schizoaffective disorders responded better to treatment than those with schizophrenia.
• Patients tended to require fewer mood agents at discharge than at admission.
• Symptom improvement was positively associated with a lower total antipsychotic dose at the time of discharge.

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References